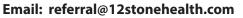
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





ORENCIA ORDER FORM					
Date: ICD-10 Code:				Therapy Status	
Patient Name:	Allergies:	Allergies:		☐ New Start	
1	Weight:Ibs OR		Continuing Therapy: Last Dose:		
PROVIDER INFORMATION					
Ordering Provider: Provider Fax:					
Provider NPI:			Provider Address:		
Provider Phone:					
MEDICATION ORDER					
Orencia	□ Infuse Orencia per weight-based dosing guideline below: IV at weeks 0, 2 and 4 followed by every 4 weeks thereafter per protocol. □ Infuse Orencia per weight-based dosing guideline below: IV every 4 weeks per protocol. ✓ Weight-Based Dosing Guidelines: Less than 60kg: 500mg dose 60kg to 100kg: 750mg dose More than 100kg: 1,000mg dose	Refills for one y	e unless elow.	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion: ✓ Hepatitis B Surface Antigen. ✓ Negative TB result and date:	
PRE-MEDICATIONS					
Oral ☐ Acetamino ☐ Loratadine ☐ Cetirizine: ☐ Diphenhyo ☐ Famotidine ☐ Ibuprofen: ☐ Ondansetr	☐ Diphenhy ☐ Famotidir ☐ Methylpre ☐ Hydrocori ☐ Ondansei	□ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg			
LAB ORDEI	cy) OTI	OTHER REQUIRED DOCUMENTATION			
**Surveillance lab	to 800-223-406 • History & Phy • Patient Demo • Medication Li	 (Please fax this signed order form, along with the following documents to 800-223-4063) History & Physical, Last Office Visit Note Patient Demographics and Insurance Information Medication List Recent Lab Work 			
By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW) By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.					
Dispense as Written:		Substitution All	Substitution Allowed:		
Prescriber Sign	criber Signature Date Prescriber S		nature	Date	